



# Presuming incapacity in anorexia nervosa is indefensible: A reply to Ip

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## Abstract

Eric C. Ip has recently argued that seriously anorexic service users ought to be assumed to be legally incapacitous to refuse life-saving artificial nutrition unless they can demonstrate otherwise, reversing the ordinary legal presumption in place to protect patients' liberty and values. In this response, I argue against this proposal on two grounds. Firstly, the proposal is wrongfully discriminatory; it would expose service users to serious harm, and wrong them in numerous ways, on the basis of their diagnosis alone, without significantly benefitting them in any way relative to the status quo. Secondly, he is unable to show that a large majority of such service users actually *are* incapacitous to refuse life-saving artificial nutrition. This means that his proposal would likely involve declaring a large number of actually capacitous patients to be incapacitous, without even the requirement of a formal assessment, and burdening them with the responsibility of proving their clinical team wrong if they wish to avoid deprivation of liberty and/or compelled treatment. Given this, his proposal is indefensible.

## KEYWORDS

anorexia, capacity, discrimination, injustice, autonomy, refusal of treatment

## 1 | INTRODUCTION

In a recent article,<sup>1</sup> Eric C. Ip argues that the decision reached in the case of *Re E (Medical Treatment: Anorexia)*, heard by the Court of Protection for England and Wales, was ethically and legally correct.

Ip agrees with the two main decisions reached in *Re E*:

1. *E* lacked the capacity to refuse life-sustaining treatment (including artificial feeding) both at the time of the proposed treatment and when she gave her advance directive.
2. *E*'s best interests were served by imposing life-sustaining treatment on her against her will, as well as by the development of a further treatment plan.

He also makes a more general ethico-legal proposal in light of his arguments for those conclusions:

3. If their capacity to refuse life-saving nutrition, either contemporaneously or as an advance directive, is impugned, patients with anorexia nervosa should be *assumed to be incapacitous<sup>2</sup> with respect to such decisions*, with the service user having to meet a 'high standard of proof'<sup>3</sup> in order to overturn this assumption.

In this response, I will not take issue with (1) or (2); i.e., the legal judgment reached in the specific case of *Re E*. I remain neutral on

<sup>1</sup>Ip, E. C. (2019). Anorexia nervosa, advance directives, and the law: A British perspective. *Bioethics*, 33, 931–936.

<sup>2</sup>Ibid: 936.

<sup>3</sup>Ibid: 936.

whether the correct legal decision was ultimately reached by the Court of Protection for England and Wales in that case.

Instead, I focus my attention on (3), which proposes to reverse the ordinary burden of proof in the case of capacity judgments when it comes to service users with anorexia nervosa refusing life-saving nutrition. I argue that this proposal should be rejected on two grounds. Firstly, we have good reason to believe that it would (a) cause significant harm to a vulnerable group of service users, and (b) lead them to have worse clinical outcomes than they currently do. This harm, in my view, is far more significant than that involved in continuing to (defeasibly) presume capacity in such cases. Secondly, I argue that, in any case, Ip does not provide adequate reason to think that service users presenting with long-term anorexia nervosa typically lack capacity to refuse life-sustaining nutrition (though many will, of course). This means that his proposal, if enacted, will likely deny liberty and forcefully impose treatment on a large number of capacitous service users (which might be less euphemistically described as detaining and assaulting them).

## 2 | THE HARMS OF PRESUMING INCAPACITY

It is first worth noting, by way of background, that Ip's proposal would be enormously revisionary of established U.K. law if implemented. It demands that we invert the very first core principle of the Mental Capacity Act 2005 (MCA)—'A person must be assumed to have capacity unless it is established that he lacks capacity'.<sup>4</sup> Ip is proposing that, in the case of service users with severe anorexia refusing life-saving nutrition, we presume that they *lack* capacity unless they can positively establish that they possess it. This is not, I admit, a reason in itself to believe the proposal is misguided—it is possible that the MCA is a fundamentally flawed piece of legislation, after all—but it suggests that Ip's proposal bears a significant burden of proof. He should, minimally, show us that (a) the vast majority of severely anorexic service users are indeed incapacitous to refuse life-saving nutrition, and that (b) the reversal of the ordinary legal assumption will be all-things-considered *good* for the service users subject to it (i.e., that its consequences will, for the most part, be in their best interests). Extraordinary claims, as always, require extraordinary evidence. In this section, I will argue against (b). I will tackle (a) in Section 3.

So, would Ip's proposal generally work in the best interests of severely anorexic service users? Ip claims that it would, because we have good reason to believe that such service users are '*de facto* suicidal',<sup>5</sup> and thus that overriding their refusals (something we can only legally do if they are deemed incapacitous) will allow us to save their lives. Undoubtedly, overriding someone's refusal of treatment *can* be immediately life-saving in cases of anorexia, just as it is can be

elsewhere in medicine. The important questions, of course, which Ip never addresses, are (i) whether the policy of inverting the ordinary presumption is likely to prevent more harm than it will cause, and (ii) whether the same benefits could be achieved by way of a less restrictive alternative policy.

On (i), note that, on the face of it, Ip's proposal constitutes direct discrimination on the grounds of disability; it advocates for a legal burden to be imposed on a certain group of people that does not apply to anybody else, simply on the grounds that they have a particular chronic mental health condition. This should strike us as a significant wrong at the core of Ip's proposal, unless he is willing and able to do one of two things. Firstly, he could try and articulate quite general, disability-neutral grounds for inverting the ordinary presumption of capacity in this way, which *just so happens* to vindicate inverting the presumption of capacity across the board in cases of anorexia. His paper does not follow this strategy. Secondly, he may attempt to explain what it is about anorexia specifically that undermines capacity to refuse life-saving artificial nutrition (thus presumably making this 'status'-based presumption of incapacity compatible with justice). This is the strategy that he in fact pursues, and that I address in Section 3.

For now, it is important to note that the legal burden imposed by a presumption of incapacity is not a trivial one. A person's capacity to refuse treatment is typically only impugned when clinicians believe that imposing treatment would be in their best interests; that is, when clinicians are willing to coerce someone into treatment, if necessary. Forcing somebody to receive life-saving nutrition against their wishes is viscerally unpleasant for everybody concerned; it not only involves the use of a nasogastric tube or other highly invasive device, but often also some form of chemical restraint or sedation to prevent the individual simply removing the tube themselves.<sup>6</sup> The likely struggle involved in conducting all of these procedures also significantly increases the risk of a secondary infection arising from improper insertion of, or subsequent disturbance to, the nasogastric or parenteral line.<sup>7</sup> So, being presumed incapacitous makes it easier for someone to be exposed to practices which, on the face of it, are significantly harmful and degrading.<sup>8</sup>

It is relevant here that in the context of prisoners on hunger strike, force-feeding by nasogastric line has been prohibited since 1975 by the Declaration of Tokyo,<sup>9</sup> which seeks to prevent physician involvement in torture and other inhumane and degrading practices. So, not only does Ip's proposal seem to discriminate against those with severe anorexia, by imposing a legal burden on them that others

<sup>4</sup>Mental Capacity Act 2005 (c1) London. HMSO.

<sup>5</sup>Ip, *op. cit.*, p. 935.

<sup>6</sup>Neiderman, M., Zarody, M., Tattersall, M., & Lask, B. (2000). Enteric feeding in severe adolescent anorexia nervosa: A report of four cases. *International Journal of Eating Disorders*, 28(4), 470–475.

<sup>7</sup>Hart, S., Franklin, R. C., Russell, J., & Abraham, S. (2013). A review of feeding methods used in the treatment of anorexia nervosa. *Journal of Eating Disorders*, 1(36)

<sup>8</sup>I do not mean to suggest by this that nasogastric or parenteral feeding is *intrinsically* harmful or degrading; only coerced versions of these interventions have these qualities, *prima facie*.

<sup>9</sup>World Medical Association (1975). Declaration of Tokyo (Art. 6).



do not have, it seems to discriminate against them in a manner that will disproportionately expose them to medical procedures that, while potentially life-saving, are also potentially torturous.<sup>10</sup> This fact alone should give Ip pause.

But suppose you are not yet convinced that the risk of harm here outweighs the life-saving potential of reversing the presumption of capacity. There is also reason to believe that such a policy will lead to worse clinical outcomes for this service-user population, by undermining trust in therapeutic relationships. A common feature of severe and persistent anorexia is that service users may have conflicting desires and motivations about continuing to lose weight; that is, although desperate to continue losing weight they may also want to seek out medical assistance to regain weight and/or to lessen the desire to lose it<sup>11</sup>—referred to in the literature as ‘ambivalence’. Nevertheless, they may also, quite reasonably, wish to avoid treatment that involves general deprivation of liberty or force-feeding more specifically (i.e., they may reasonably prefer less restrictive approaches to recovery, even in the short-term). This ambiguous motivation and the risk involved in being found incapacitous to refuse artificial nutrition can already make it hard to seek out help. This will only be made worse if service users know that the *mere impugning* of their capacity by the clinical team will be sufficient to deprive them of their legal right to refuse treatment, until such a time as they are able to demonstrate that the clinicians are wrong. In other words, removing a presumption of legal capacity for those with severe and enduring anorexia will predictably disincentivize such service users from seeking out treatment and support, as it makes that process riskier. On this point, it is worth noting that this disincentive may be particularly motivationally powerful for service users with anorexia, since regaining a sense of control over one’s life and body is an important motivating factor for their restrictive behaviour.<sup>12</sup> So, not only might anorexic service users reasonably wish to avoid the heightened risk of compulsory treatment, as might anybody, but the threat of loss of control and decision-making power may directly contribute to both their symptomatology *and* their specific motivations for avoiding seeking support.

Even if such service users *do* present for help, despite the heightened risks involved, they will have much stronger reasons to lie to or mislead the clinical team about the extent of their symptoms and suffering (at least for those that they can hide or disguise), since they will have extra motivation to convince them that a finding of incapacity (which is much easier to make under Ip’s proposal) is unnecessary. This will limit the clinical team’s ability to help, and underscores both (a) the deleterious consequences of a loss of trust in

therapeutic relationships, and (b) the deleterious effects on therapeutic trust that can be precipitated by shifting the balance of power in clinical relationships further *against* service users.<sup>13</sup>

Quite apart from the consequential harms that will accrue from this policy, in virtue of its imposing additional risk on service users and undermining the therapeutic relationship, we should not underestimate the intrinsic wrong of imposing undue risk on service users who may otherwise honestly disclose the severity of their symptoms to clinical teams. When service users choose to avoid exposing themselves to the vastly expanded institutional power wielded by clinicians in a world where Ip’s policy is enacted, either by avoiding contact altogether or by playing down their symptoms, we might sensibly conclude that they are being *unjustly silenced*. That is, we might think that they are responding quite reasonably to the extreme threat that disclosure now poses to them, and choosing, under duress, to remain silent or truncate the truth. This bears a striking resemblance to Kristie Dotson’s notion of ‘Testimonial Smothering’<sup>14</sup> and may even, depending on one’s exact understanding of that category of wrong, be an instance of it.<sup>15</sup> This silencing of service users may even violate their right to access healthcare, since it makes the disclosure necessary to claim healthcare an unnecessary threat to their liberty and autonomy.

Finally, it is worth noting that the good of saving lives, which Ip rightly values immensely, can demonstrably be achieved by less restrictive means. There is little evidence that the current legal status quo, which grants service users with anorexia (at least *de jure*) a presumption of capacity, fails to license coercive treatment necessary to protect their lives, when this is in their best interests. Cases where the capacity of anorexia patients is disputed and which appear before the Court of Protection *already* almost invariably find that service users are incapacitous to refuse artificial nutrition, with force-feeding only not commencing when it is found not to be in their best interests.<sup>16</sup> Given this, it is unclear what benefit Ip actually hopes to gain by removing an important legal presumption in favour of capacity to refuse (i.e., what he hopes to gain by forcing more service users to go to the Court of Protection to *prove* their capacity).

If he believes that a significant group of actually incapacitous service users are currently being left to get sicker and/or die as a result of the legal burden of *demonstrating* this incapacity, then he should provide evidence for that. I can find none. If he does not believe this, then one wonders what he thinks a presumption of incapacity

<sup>10</sup>The point here is not that I believe all occasions of coerced feeding to be inhumane, degrading, or torturous, or to be outlawed by the Declaration of Tokyo. Rather, I am pointing out the consensus view that these interventions have very serious and immediate consequences, to which we should be extremely cautious about exposing service users, and to which Ip’s proposal would risk exposing more people.

<sup>11</sup>Hope, T., Tan, J., Stewart, A., & McMillan, J. (2013). Agency, ambivalence and authenticity: The many ways in which anorexia nervosa can affect autonomy. *International Journal of Law in Context*, 9, 20–36.

<sup>12</sup>Gregertsen, E., Mandy, W., & Serpell, L. (2017). The egosyntonic nature of anorexia: An impediment to recovery in anorexia nervosa treatment. *Frontiers in Psychology*, 8, 2273.

<sup>13</sup>C.f. Verbeke, E., Vanheule, S., Cauwe, J., Truijens, F., & Froyen, B. (2019). Coercion and power in psychiatry: A qualitative study with ex-patients. *Social Science & Medicine*, 223, 89–96.

<sup>14</sup>Dotson, K. (2011). Tracking epistemic violence, tracking practices of silencing. *Hypatia*, 26(2), 236–257.

<sup>15</sup>The main point of contention here would, I imagine, be over whether the risk facing the service user in our case is in part a function of the pernicious ignorance of their audience (clinicians) on the topic of their lives and experiences (as Dotson requires for applying the concept of ‘Testimonial Smothering’). Regardless of what one thinks about this issue, we should agree that the case before us shares with Testimonial Smothering an imposition of significant and avoidable risk to welfare as the cost of honest disclosure.

<sup>16</sup>Clough, B. (2016). Anorexia, capacity, and best interests: developments in the court of protection since the Mental Capacity Act 2005. *Medical Law Review*, 24(3), 434–445.

could achieve that would outweigh its many and varied harms. This is all true, crucially, even if I grant him the claim that most severely anorexic service users *are in fact* incapacitous to refuse life-saving artificial nutrition. Most of the harms I described above accrue both to those who are incapacitous *and* to those who are capacitous who would be forced to demonstrate this fact. If his concern is, in fact, for those individuals for whom it is found that force-feeding would not be in their best interests, then on whom the burden of demonstrating (in)capacity falls is irrelevant to this matter, since their presumption of capacity is typically defeated in the normal way.

All of this speaks against Ip's proposal, in my view, whether it is taken to include only contemporaneous or also advance refusal of artificial nutrition. Yet it is possible, I suppose, that some will disagree with how I am choosing to weigh the moral situation here, or with how I have understood the harms to service users under the status quo. Maybe presuming capacity *really does* expose service users to greater risk of deterioration than I have allowed, or perhaps my concerns about the alternative position are not as powerful as I have made out.

If so, then we must *at least* ensure that Ip's grounds for believing that the majority of severely anorexic service users are incapacitous to refuse life-saving artificial nutrition are solid. Otherwise, the obvious risk of wrongly stripping a large number of service users of their legal right to refuse treatment would surely be unjustifiable; one must believe that those who experience this wrong will be few and far between (and, hopefully, readily identifiable and able to defend themselves). In the next section, I show that Ip's argument for this is unable to demonstrate the pervasive incapacity necessary to make Ip's proposal defensible.

### 3 | ANOREXIA AND INCAPACITY TO REFUSE ARTIFICIAL NUTRITION

Throughout his paper, Ip consistently speaks of the 'principle of autonomy' (and similar moral rules and principles) not being *absolute* in cases of anorexia.<sup>17</sup> If this is understood as a claim that people with anorexia often experience some impediment to their exercising of their autonomous capacities, then this is probably true. But it is also much weaker than is needed to defend his proposal. We must be careful not to lump cases of (somewhat) impaired autonomy together with cases of incapacity; there are many plausible ways for one's autonomy to be impaired that do not amount to incapacity,<sup>18</sup> as traditionally understood by the MacArthur criteria<sup>19</sup> (which underpin the U.K.'s MCA) and cap-

tured by the MacCAT-T competence assessment.<sup>20</sup> This is important, because it may undercut any reason Ip gives us to presume incapacity (even if we think that Ip succeeds in giving us good reason to assume impaired *autonomy*).

A reason *in favour* of Ip's proposal needs, I submit, at least two features. It must (i) point to a widespread (indeed, near-universal) feature of severe and persistent anorexia that (ii) systematically undermines a decision-making ability in such patients sufficient to render them without capacity to refuse nutrition *according to the MCA* (or at least according to the underlying MacArthur criteria). That is, whatever feature of anorexia Ip identifies must be near-uniformly capacity-undermining (not merely detrimental to the exercise of full autonomy) and must be near-universally present in the patient population. Otherwise, any presumption of incapacity on the basis of anorexia would wrongly place a tremendous legal burden on a significant number of individuals, and/or undermine the core of the legal and clinical construct of capacity, both in the U.K. and more widely. My argument in this section shows that Ip's argument cannot meet these requirements.

Distinguishing incapacity in the legal sense from impaired autonomy more generally is critical when it comes to evaluating the significance of Ip's claim that it is a characteristic *belief* about weight or body size that undercuts service-users' autonomy.<sup>21</sup> Though Ip's characterization of these beliefs is rather too brief (and misleading—I will say a bit more about this in a moment) and so difficult to evaluate in relation to his argument, he is right that *prima facie* false beliefs about size and weight are often present in anorexia. These are typically referred to in the literature as 'overvalued ideas'.<sup>22</sup>

Under the MCA 2005, an individual has capacity unless they are unable to understand, retain, or use and weigh the information pertinent to the decision, or cannot express a decision (because, e.g., they are unconscious).<sup>23</sup> It is important to reflect on which of these capacities even the most intractable and harmful false belief might be able to undermine. It is quite apparent that characteristic false beliefs of the kind Ip invokes to justify presumptive incapacity are not able to undermine retention or communication. I also submit that they could not, by themselves, undermine one's ability to use and weigh information, since this refers to the *process* of decision-making, which is not directly influenced by the content of the beliefs used in that process, or by the conviction with which they are held. A decision-making process may even be *perfectly procedurally rational* (a standard which presumably encapsulates the degree of ability to use and weigh information required for capacity by the MCA

<sup>20</sup>Grisso, T., Appelbaum, P. S., & Hill-Fotouhi, C. (1997) The MacCAT-T: A clinical tool to assess patients' capacities to make treatment decisions. *Psychiatric Services*, 48(11), 1415–1419.

<sup>21</sup>Ip, op. cit., p. 935.

<sup>22</sup>Gadsby, S. (2017). Explaining body size beliefs in anorexia. *Cognitive Neuropsychiatry*, 22(6), 495–507; Gadsby, S. (2020). Self-deception and the second factor: How desire causes delusion in anorexia nervosa. *Erkenntnis*, 85, 609–626; Mountjoy, R. L., Farhall, J. F., & Rossell, S. L. (2014). A phenomenological investigation of overvalued ideas and delusions in clinical and subclinical anorexia nervosa. *Psychiatry Research*, 15, 507–512.

<sup>23</sup>Mental Capacity Act 2005 (c3).

<sup>17</sup>Ip, op. cit.

<sup>18</sup>Tan, J. O. A., Stewart, A., Fitzpatrick, R., & Hope, T. (2006). Competence to make treatment decisions in anorexia nervosa: Thinking processes and values. *Philosophy, Psychiatry & Psychology*, 13(4), 267–282.

<sup>19</sup>Appelbaum, P. S., & Grisso, T. (1995). The MacArthur Treatment Competence Study. I. *Law and Human Behavior*, 19, 105–126.



2005) while being based on false beliefs that the agent in question holds with absolute conviction.

So that leaves us to consider the ability to *understand* relevant information. It is at least plausible that a sufficiently stable and intractable false belief about one's own weight could undermine one's ability to 'understand the information relevant to the decision' (since one's dangerously low weight presumably counts as relevant information when it comes to refusing nutrition). Let us assume then, that it is this dimension of capacity that Ip thinks is systematically undermined by anorexic service-users' overvalued ideas,<sup>24</sup> and that information relevant to refusing artificial nutrition includes one's own weight or size, since it partly determines the risk to one's life and health should treatment be refused.

Crucially, although such beliefs *may* cause somebody to perform badly on the 'understanding' or 'appreciation' dimensions of the MacCAT-T, very many service users who hold these overvalued ideas nevertheless perform well on such dimensions,<sup>25</sup> and most overvalued ideas are thought to be well below the intractability threshold that would allow them to be counted as 'delusions'.<sup>26</sup> It is therefore unlikely that such overvalued ideas, held with sufficiently intractable conviction to undermine capacity, are widespread enough within Ip's target patient population to justify his overturning a presumption of capacity.

Even if we are extremely charitable and assume that such overvalued ideas are sufficiently *widespread* to ground the kind of generalization that Ip relies on,<sup>27</sup> there is another reason, on closer inspection, to think that service users who hold them will not thereby systematically lack capacity. Research involving interviews with anorexic service users suggests that what are supposedly false beliefs about their objective weight and size and the danger those states pose are often more akin to value-judgments about their weight, driven by negative feelings about themselves. That is, they are statements that ultimately mean that the individual is too fat *by their own lights*.<sup>28</sup> This is important for two reasons, aside from the fact that they may be better understood as values rather than as straightforward beliefs as Ip suggests.

Firstly, they may be true (insofar as they merely report preferences), even when a service user is dangerously thin. Secondly (and, in part, consequently), they cannot be said to undermine a service-user's understanding of information pertinent to a decision to refuse artificial nutrition. This is because a belief that one is too fat by one's own lights is perfectly consistent with fully acknowledging that one is perilously thin, and yet continuing to value further weight loss

more highly than the avoidance of harm or death. In such cases, a patient understands what is at stake, but then weighs it up in a manner that reflects unusual, even aberrant, values. By the lights of the MCA this amounts to, at worst, an unwise decision, not to one made without capacity. So, anorexic service users in the grip of overvalued ideas cannot, on that basis alone, be said to be unable to understand information pertinent to the decision to refuse food. At best we may say that they are more likely than most to weigh such information in an unusual and personally harmful way when making such decisions, which does not, and should not, amount to incapacity.

Ip's argument fails because the beliefs he highlights as capacity-undermining are not at all uniform in their potential to undermine capacity. A quick look at recent literature on autonomy and capacity in anorexia nervosa makes this unsurprising. Much of the surge, in the last 10–20 years, of research interest in the area is driven by the recognition that many anorexic service users do remarkably well in passing standard tests of capacity, even while endangering their lives.<sup>29</sup> Such research tends, instead, to emphasize that service-users' autonomy (and sometimes their capacity too, understood in a non-traditional way) may be undermined by *pathological values* characteristic of anorexia, such as an overridingly intense desire or urge to lose weight, or other *affective features* of the condition, such as intense fear of weight gain.<sup>30</sup> Might these other mental features of service users with severe and persistent anorexia provide the kind of widespread, capacity-undermining feature that Ip would need to begin defending a presumption of incapacity?

The answer, I think, is no. But I cannot fully defend this claim in a short discussion note. I will, instead, simply note the following: none of the authors who emphasize these features of anorexia even so much as *suggest* that an inversion of the ordinary presumption of capacity would be an appropriate response. They tend, quite rightly in my view, to limit themselves to suggesting that tests of capacity perhaps need to be revised to properly take account of such factors (no small challenge in itself, since capacity law rightly dislikes wandering into the realm of evaluating individuals' *values*). They have very good reasons for limiting themselves in this way, all of which echo what I have already discussed here: such features may not be sufficiently widespread nor uniformly capacity-undermining and, moreover, these authors are aware that the consequences of implementing such a reversal of the ordinary presumption would be very grave indeed. They are also mindful of the fact that the full benefits of their insights could be realized by incorporating such features into capacity tests, and that there is therefore no *benefit* to using them as grounds for overturning a presumption of capacity.

The presumption of capacity to refuse treatment is a cornerstone of modern bioethics and medical law; it provides a much-needed safeguard against clinical overreach, and prevents doctors' values supplanting those of their patients, giving the latter

<sup>24</sup>Though Ip rather quickly glosses over how exactly overvalued ideas undermine capacity with reference to the MCA, he does briefly mention understanding as being a significant part of the issue, so this assumption seems fair (Ip 2019, op. cit. p. 935).

<sup>25</sup>Tan et al. 2006, op. cit.; Tan, J. O. A., Hope, T., & Stewart, A. (2003). Anorexia Nervosa and personal identity: The accounts of patients and their parents. *International Journal of Law and Psychiatry*, 26, 533–548.

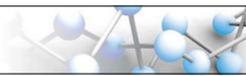
<sup>26</sup>Gadsby 2017, op. cit.

<sup>27</sup>In fact, there is some evidence that many service users may lack them altogether (Gadsby 2017, op. cit., p. 497).

<sup>28</sup>Hope et al., op. cit., p. 28

<sup>29</sup>Tan et al., op. cit., 2003; Tan et al. 2006, op. cit.; Hope et al., op. cit.

<sup>30</sup>Tan et al. 2006, op. cit.; Tan, J. O. A., Stewart, A., & Hope, T. (2009). Decision-making as a broader concept. *Philosophy, Psychiatry & Psychology*, 16(4), 345–349; Charland, L. C., Hope, T., Stewart, A., & Tan, J. (2013). Anorexia nervosa as a passion. *Philosophy, Psychiatry & Psychology*, 20(4), 353–365; Hope et al., op. cit.



much-needed control in guiding the course of their lives and, if they so choose, their deaths. While individuals obviously sometimes need protection when they are unable to make decisions for themselves, there is no good reason to brand somebody as being incapable in this way solely on the basis of a diagnostic label, something that commentators are already concerned the Court of Protection for England and Wales is straying towards.<sup>31</sup> We must reject the sort of overt discrimination implied by proposals like Ip's, or risk slipping back to the truly dark days of almost completely unchecked psychiatric compulsion.

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<sup>31</sup>Cave, E., & Tan, J. (2017). Severe and enduring anorexia nervosa in the Court of Protection in England and Wales. *International Journal of Mental Health and Capacity Law*, 23(4), 4–24.

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